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MANAGED CARE IN THE MILITARY HEALTH SERVICES SYSTEM: DID DOD PROPERLY PLAN AND WILL IT SUCCEED OR FAIL?

by

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This paper addresses implementation of the managed care program in the Military Health Services System (MHSS). Two specific questions to be addressed are: did the Department of Defense (DOD) properly plan and prepare to implement managed care in the Military Health Services System?; and will a lack of planning and preparation cause managed care to fail? First to be addressed is a brief background of managed care in the civilian sector and why it has been successful. Next, three specific processes of the Department of Defense managed care program, called TRICARE, will be discussed. These processes are marketing, information systems and reimbursement procedures. Each process is evaluated through a review of DOD policies; government managed care contracts and implementation guidelines. The wide array of government policies and guidelines used to evaluate each process were developed both before and after the implementation of TRICARE. Finally, the likelihood of success or failure of TRICARE will be addressed. There are no conclusions to be drawn yet. The TRICARE program is too new for any findings to have been determined. It will be several more years before anyone can tell if TRICARE will succeed or fail.

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Preface

The topic of managed care in the Military Health Services System (MHSS) was selected because it is a program which affects everyone currently in the military and their dependents, as well as, those who have retired from the military and their dependents. I have been in the Air Force 13 years and have been involved in various aspects of hospital administration. It has been my desire to do all I can to provide those who depend on military health care with the best possible service and quality health care.

It is my opinion managed care in the military sector will not provide quality health care at needed levels to all eligible beneficiaries who wish to receive care from the military system. I do believe the process of managed care is a viable option to improve health care delivery in the civilian sector. This causes me to have great concern when the government invests 15 billion dollars into a system, which will not provide the needed services to the beneficiaries and will not work as originally intended.

This project investigates why lack of planning and preparation on the part of the government, prior to implementation, may cause managed care to fail in the Military Health Services System. Three processes; marketing, information systems, and reimbursement procedures, which are important to the success of any managed care program, will be addressed to substantiate why I believe managed care may fail. I would like to thank LCDR Donald McBrayer for his guidance and recommendations in the development of this paper.

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Abstract

This paper addresses implementation of the managed care program in the Military Health Services System (MHSS). Two specific questions to be addressed are: did the Department of Defense (DOD) properly plan and prepare to implement managed care in the Military Health Services System?; and will a lack of planning and preparation cause managed care to fail? First to be addressed is a brief background of managed care in the civilian sector and why it has been successful. Next, three specific processes of the Department of Defense managed care program, called TRICARE, will be discussed. These processes are marketing, information systems and reimbursement procedures. Each process is evaluated through a review of DOD policies; government managed care contracts and implementation guidelines. The wide array of government policies and guidelines used to evaluate each process were developed both before and after the implementation of TRICARE.

Finally, the likelihood of success or failure of TRICARE will be addressed. There are no conclusions to be drawn yet. The TRICARE program is too new for any findings to have been determined. It will be several more years before anyone can tell if TRICARE will succeed or fail.

Chapter 1

Introduction

> *No plan of operation can with any certainty extend beyond the first encounter.*
>
> —Helmuth von Moltke

The purpose of this paper is to focus on the topic of the Department of Defense (DOD) planning and preparation prior to the implementation of the managed care program call TRCARE. Specifically, two questions will be addressed. First, did the DOD properly plan and prepare to implement managed care in the military health care system? Second, will the lack of planning and preparation cause managed care to fail? Three processes important to any managed care program will be investigated to prove the DOD did not properly plan or prepare prior to writing the Request for Proposal (RFP) for the Managed Care Support Contract (MCSC) or implementing TRICARE. The three processes to be used in this paper are the marketing of TRICARE, the information systems used in the daily operations of TRICARE, and the reimbursement procedures for TRICARE between the DOD and the managed care Contractors. There are many other processes, which could be investigated, however this paper does not allow enough space to address other areas of interests. Without these three basic elements, any managed care program would fail.

Managed care plans combine the delivery of health care services with the financing of that care. By enrolling in a managed care plan such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), a person agrees to receive their health care from a select group of physicians, hospitals, and other service providers in exchange for paying a set fee each month for the services they receive.[1] Managed care began in the United States in the early 1900's in the form of pre-paid group practices. These were developed to provide coordinated health care in a cost-effective way. Though World War II did accelerate the growth of these plans, it was the passage of the Federal HMO Act in 1973 that truly spurred the growth of managed care. By early 1997, one-half of the total population was in some type of managed care plan. Seventy four percent of those receiving their health insurance through their employer, 13 percent of Medicare beneficiaries and 42 percent of Medicaid beneficiaries were enrolled in a managed care plan.[2]

The mission of the Military Health Services System (MHSS) is to provide medical services and support to the armed forces during military operations. In addition, the MHSS provides continuous peacetime medical services to members of the armed forces and their dependents, retirees and their dependents, and others entitled to Department of Defense (DOD) medical care. Military medical treatment facilities (MTFs) are the heart of the military health care delivery system, providing about 75 percent of all care. Civilian care, financed through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) comprises a much smaller portion and is designed primarily to supplement care available in military facilities.

Consistent with National Health Care Reform, the military health care system embarked on a major program of health care reform—TRICARE. TRICARE is a managed care program designed to ensure the most effective execution of the military health care mission, recognizing the need to ensure access to a secure, quality health care benefit, control costs, and respond to changing national military and health care priorities.

The DOD began its transition to managed care on October 1, 1993, adding four major features to its health care program that provide MTF Commanders the tools, authority and flexibility to manage better in an era of health care reform. The first added feature is division of the United States-based MHSS into 12 Health Service Regions; each headed by a medical center Commander designated as a Lead Agent, who has broad responsibilities for health care management throughout the region.

Second is the development of proposed standard managed care options for CHAMPUS eligible beneficiaries: a health maintenance organization (HMO) type option known as TRICARE Prime and a preferred provider (PPO) option known as TRICARE Extra; both alternatives to standard CHAMPUS or, as it is now known, TRICARE Standard. CHAMPUS beneficiaries retain their freedom to choose among several health care alternatives and the opportunity to elect enrollment in an option that lowers their out-of-pocket costs.

The third change is a transition to a capitation-based method of allocating health care resources to the Military Departments, which provides financial incentives for effective health care management. The final added feature is transition to the establishment of a fixed price, at-risk TRICARE managed care support contract to operate in each health service region, offering fiscal and administrative support to lead

agents for care purchased from networks of civilian health care providers.[3] Although there are 12 regions, only seven contracts were developed. Some contracts will cover two regions.

The policy guidelines describe, in theory, the principles and design of the DOD TRICARE program. However, since 1993, there has been slow progress toward managed care for the DOD. To date, the last of seven contracts has yet to be finalized. The following chapters will address just three processes needed to have a successful managed care plan. Chapter two will address marketing issues, chapter three will investigate problems with the information systems used by the DOD to conduct TRICARE, and chapter four will discuss the reimbursement procedures. Chapter five will conclude this paper with a summary of information and implications of the material presented as to how TRICARE will succeed or fail.

Notes

[1] "What Is Managed Care," *AARP Managed Care Consumer's Guide,* 4 December 1997, n.p.; on-line, Internet, 29 December 1997, available from http://www.aarp.org/monthly/managedcare/whatismc.html.

[2] "A History of Managed Care," *AARP Managed Care Consumer's Guide,* 4 December 1997, n.p.; on-line, Internet, 29 December 1997, available from http://www.aarp.org/monthly/managedcare/whatismc.html.

[3] Department of Defense, *TRICARE Policy Guidelines* (Washington, D.C.: Office of Assistant Secretary of Defense [Health Affairs]), May 1995.

Chapter 2

Marketing of TRICARE

This chapter focuses on the need to perform proper marketing techniques before implementing a major program and how these marketing techniques are (or are not) being applied to the Department of Defense (DOD) managed care program; TRICARE. It is important for any organization, which develops a new product or service to conduct market research to ensure the efforts, and resources of the organization are not wasted. Since the DOD is financed by taxpayer dollars, it is important to everyone who pays taxes to know the government is doing everything possible to protect limited resources and use them wisely.

Planning and marketing define a health care organization's basic response to its environment. They are resource allocation decision processes, which must meet the twin test of realism (fit with the realities of the customer and provider markets) and conviction (convincing individual patients and workers the decisions are in their personal best interests).[1] Marketing can be defined as the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives.[2] These two definitions provide the basis for a look into the marketing efforts of TRICARE.

The DOD 1996 TRICARE Marketing Plan, developed by Health Affairs, and distributed to all Lead Agents establishes the guidance for marketing TRICARE at all levels of DOD. The introduction to the plan states the Office of Assistant Secretary of Defense-Health Affairs TRICARE Marketing Office (TMO) was established to unify marketing activities, provide overall direction to the TRICARE marketing effort, and coordinate the production and dissemination of generic communication products (advertising and public affairs materials). It goes on to state marketing involves more than just "selling" or "advertising." It involves integrating five major marketing activities:

1. identify customers and their needs;
2. develop products and services to meet customer needs;
3. communicate to customers their needed products and services are available and where;
4. provide products and services in a customer-satisfying manner; and
5.) measure the degree to which customer needs are satisfied.[3]

This plan is full of contradictions between what the DOD wants to provide and what it can provide after severe cutbacks in facilities, funds, and personnel. The plan uses all the textbook words and states the typical steps normally found in a marketing plan. However, it provides minimal data collection and analysis, and there is no indication the marketing activities mentioned above were performed. The plan begins with a Situation Analysis. The forecast indicates the Military Health Services System (MHSS) is one of the nation's largest health care systems, offering benefits to about 8.2 million people at an annual cost exceeding 15 billion dollars. The mission of the MHSS is to provide top quality health services, whenever and wherever needed to members of the Armed Forces, their families, and others who are entitled to DOD health care. The forecast projects that

by 1999, more than 8 million people will remain eligible to receive care through the MHSS. Retirees, and their families will make up a larger share than ever before, more than 50 percent.

What does the implementation of managed care do for the 8.2 million MHSS beneficiaries, do they want it, and how is the DOD marketing TRICARE to beneficiaries and providers of military health care? First, one must know that prior to TRICARE, lack of access to military Medical Treatment Facilities (MTFs) was the number one complaint from MHSS beneficiaries. In addition, the priority of care was Active Duty members, their dependents, retirees, their dependents, and survivors. Eligible beneficiaries other than Active Duty who could not access the MTF relied on CHAMPUS to receive care in the civilian sector. Under TRICARE, beneficiaries have the option to enroll in TRICARE Prime (HMO) at the MTF or with the civilian Contractor. They also have the option of not enrolling and use the Contractor's TRICARE Extra (PPO) network, or to use a third option, TRICARE Standard, which has higher cost shares and deductibles. This changes the priority of care given at the MTFs. Active Duty and those beneficiaries enrolled with MTFs will have priority to use the military facilities. There will be very limited space available care for Medicare patients, which now depend heavily on the MTFs for care. In addition, the retirees who now receive care for free will have to pay a yearly enrollment fee of $230 (individual) or $460 (family) to join Prime.

If the main complaint by beneficiaries is lack of access to MTFs, what becomes clear is marketing activity step (1) was not accomplished. The MHSS beneficiaries did not ask for this new product which has been thrust upon them. What TRICARE does do is eliminate Medicare beneficiaries and beneficiaries with other health insurance from using

a MTF. It also causes those beneficiaries who select the Contractor's Prime network to pay copayments every time they seek care. Even people who select the MTF Prime option will have co-pays if they are sent to the Contractor's network. This could happen frequently if a MTF enrolls too many people and cannot meet the stringent access standards required by the managed care support contract.

The DOD TRICARE marketing plan states it has developed products and services to meet customer needs. When TRICARE was first being developed in 1993, it was marketed as the answer to the problem of access for all beneficiaries. But in 1998, that has changed dramatically for beneficiaries in some regions. What customers of the MHSS need is access to health care, as promised as a benefit. Originally, TRICARE was developed to provide a uniform benefit to all MHSS beneficiaries regardless of location. The Prime option is offered in every catchment area, which is an approximate 40-mile radius around a MTF, and it can be offered in noncatchment areas provided the beneficiary population supports establishing an HMO in the area. The problem encountered in some regions is large portions of the population (up to 50 percent) reside in noncatchment areas with population bases too small to support establishing a Prime site. This leaves these beneficiaries excluded from joining the MTF Prime, and raises their deductible and copayments when they use the only option available to them - TRICARE Standard. When beneficiaries transition from CHAMPUS to TRICARE Standard their deductible and copayments will increase. This has caused many beneficiaries to ask the question "What will TRICARE do for me?" The answer is nothing! Therefore, marketing activity step (2) was not fully accomplished in some

regions because the only beneficiaries who gain from TRICARE are those who live within a MTF catchment area and already had access to care.

It is understandable that an HMO cannot be developed in areas where the beneficiary population is limited to less than 20,000, or the health care market has not progressed to managed care. However, when TRICARE was being developed it was marketed as being available to everyone in the MHSS. This also contributes to the failure to completely meet marketing activity step (3) of the DOD TRICARE Marketing Plan which states the plan will communicate to customers their needed products and services are available where they need to be. Although some regions which are MTF-rich have been more successful than others at providing needed services to all MHSS beneficiaries, other regions still have to market the TRICARE program and are facing very negative audiences when briefing the program. An attempt to provide care with no out of pocket expenses to geographically separated Active Duty members and their families have also been reduced. The military has recruiters, ROTC instructors, and other members that work in areas away from military installations. The DOD has not been able to assist these Active Duty members with providing the Prime option to them. It is simply cost prohibitive to do so. By not being able to provide Prime to people outside catchment areas and in geographically separated areas, the government has not been able to place the needed products and services where they are needed.

TRICARE has been operational since 1995, starting on the West Coast and slowly being implemented region by region toward the East Coast. It is not clearly known yet if the products and services of the TRICARE program are being provided in a customer-satisfying manner. During November and December 1996, a small telephone satisfaction

survey was conducted in regions where TRICARE Prime is operational. The Assistant Secretary of Defense, Health Affairs received the results of the survey in January 1997, however, the results were considered questionable, and were not released. According to a Health Affairs policy letter issued November 1996, a customer satisfaction survey is currently under development.[4] A Contractor who will also administer the survey and report results directly to Health Affairs will develop the survey. It will be conducted centrally under the supervision of Health Affairs and will focus on patient satisfaction with care at military MTFs. An update to the policy letter states "pilot" questionnaires are expected to be mailed to patients in mid-February 1997. The survey should enter its "routine" stage by May 1997. Of course a question, which bears asking is, "Why did Health Affairs wait two years after the start of health care delivery under TRICARE to have a customer satisfaction survey developed?" This leaves marketing activity steps (4) and (5) inadequately accomplished. It has not been determined if TRICARE products and services have been provided in a customer-satisfying manner, nor can the DOD measure the degree to which customer needs are satisfied.

The conclusion gathered from this research is the DOD did not attempt to first form focus groups to ask the customers what their needs were. Also, the DOD did not do a thorough market analysis to see if TRICARE would be the best resolution for the mounting problems of providing cost effective care, quality health care, and access to health care for all MHSS beneficiaries in a time of shrinking resources. In an attempt to control health care costs, the DOD determined TRICARE would be implemented and instead of conducting true marketing techniques as defined at the start of this chapter, the DOD has really provided public relations to educate the MHSS beneficiaries on what is

being done to them. TRICARE has created much confusion and fear not only for the beneficiaries, but also for those who work in the military health care system. There are many providers of care who do not know what TRICARE means and how it will affect the delivery of care. The implementation of TRICARE has also taken its toll on those who are responsible for the administration of health services at MTFs. MTF Commanders and Administrators have to learn how to communicate with Contractors and ensure they are meeting the requirements of the managed care support contracts. The DOD at all levels has not been successful at educating the beneficiaries and providers of care in the Military Health Services System.

Notes

[1] J.R. Griffith, *The Well-Managed Health Care Organization* (Ann Arbor MI: AUPHA Press, Health Administration Press, 1995), 226.

[2] P. Kolter and R.N. Clarke, *Marketing For Health Care Organizations* (Ann Arbor MI: AUPHA Press, Health Administration Press, 1987), 5.

[3] Department of Defense, *1996 DOD Health Affairs TRICARE Marketing Plan* (Washington, D.C.: Office of Assistant Secretary of Defense [TRICARE Management Office]), 1-9.

[4] *Office of Assistant Secretary of Defense (Health Affairs) Policy Letter for Army, Navy, Air Force Surgeons General*, HA Policy 97-012, 18 November 1996.

Chapter 3

Information Systems Used in TRICARE

TRICARE was developed to provide significantly improved beneficiary access to care; ensure a high quality, customer-focused, consistent health benefit for all Military Health Services System (MHSS) beneficiaries at no or low cost; preserve choice for all non-Active Duty participants; and contain overall DOD health care costs while maintaining medical readiness for all contingency operations. The managed care program is being implemented through seven managed care support contracts, covering 12 regions in the United States. When developing strategies and costs associated with multi-billion dollar contracts, data collection and analysis must first occur. This chapter focuses on the difficulties of the DOD to collect accurate patient level cost accounting data, and the information systems used to collect data for the implementation of TRICARE. In addition, the duplication of effort makes it difficult to contain health care costs.

In 1993, the DOD started down the long road to implementation of TRICARE. Instead of staying the course on a single road, the DOD soon found it was traveling down two treacherous paths. During the period of data collection in preparation for TRICARE, the DOD came to the conclusion there was a tremendous problem with the information systems within the DOD. The problem - over the years, 128 different information

systems had been developed for the purpose of data collection in the health services field, each being designed, funded and supported by the various Services in DOD. In addition, very few of the systems "communicate" with each other. The number of systems owned by each sponsor is:

Office of Assistant Secretary of Defense (Health Affairs)	42
Office of Civilian Health and Medical Programs of Uniformed Services (OCHAMPUS)	9
Department of the Army	36
Department of the Navy	28
Department of the Air Force	11
External to MHSS	2
TOTAL	128

The systems were not designed to collect information needed to develop and implement managed care support contracts. These systems were designed to collect data on a macro level. Currently, basic population and demographic data are available on how many patients are seen and what resources were used to care for them. However, much more micro level data is needed to determine costs of a managed care support contract. Consultants hired by the DOD had a difficult time analyzing data from different Services and other DOD health agencies. The consultants collected data, made adjustments, and balanced the outcomes against civilian industry standards. At best, the DOD paid consultants to make educated guesses based on the data collected.

The DOD realizes the success of managed care in the Military Health Services System depends on accurate and timely MTF level population and cost accounting data.

The missing data needed is micro level data on patient encounters to include clinical intensity and outcomes. A lengthy plan has been initiated to develop standardized data collection across the Services and other health agencies in the DOD[1]. The 128 information systems have been divided into three groups with the goal of deleting or combining most of the systems and ultimately finishing with four major information systems for all of the MHSS. The first group is called legacy systems, the second is interim migration systems and the third is called target migration systems[2].

Legacy systems are defined as systems scheduled for deletion. The most used legacy systems in managed care are:

1.) Defense Medical Information System (DMIS) - used to provide a large repository of patient level, population, normative, and financial data to support the formulation and execution of plans, programs and policies of Health Affairs, and supports the information needs of Services headquarters staff and health care analysts.

2.) Medical Expense and Performance Reporting System (MEPRS)—provides automated functions to standardize expense, workload, and manpower data collection, processing, and reporting practices of the DOD medical departments at each MTF.

3.) Resource Analysis and Planning System (RAPS)—provides modeling and analytical tools to project military health care population, workload, and costs. The model enables users to estimate and analyze the impact of alternative assumptions and policy decisions on resource requirements in order to identify and address problems within the MHSS.

4.) Retrospective Case Mix Analysis System For an Open Systems Environment (RCMAS-OSE)-provides a patient level case mix analysis system which provides timely

access to clinical and management information; detailed patient level data; and timely and comprehensive statistics of observed versus expected workload and utilization for analysis and evaluation by managers at local, Intermediate Headquarters, and Health Affairs levels.

All four of these systems are used on a daily basis by MTFs, and were used as a major source to collect data for the managed care contracts. The common threads, which run through the systems, are data collection on patient population, MTF workload, and cost of providing care. Unfortunately, each system reports a different outcome or result, because Services were given resources to develop separate systems, which do not communicate with each other. The same information may go into the systems but the output is altered due to the different data sets developed for each system. For example, DMIS and RAPS both provide population data. Although the same numbers are input to each system, the results are different because of different definitions used to define the population base. This leaves the MTFs, and anyone else who uses the systems with conflicting data. Another problem associated with the systems is the method used to cost out services provided to patients. Costs are batched, or totaled per encounter. When a patient is seen in the primary care clinic there is only one global charge for the visit. The current systems do not allow MTFs to collect separate data for the cost of ancillary charges.

The next group of systems is the interim migration systems, defined as systems designed to temporarily replace the legacy systems until the target systems are developed and deployed. The most commonly used interim migration systems are:

1.) Ambulatory Data System (ADS) - provides ambulatory data as a by-product of the health care delivery process. It captures patient specific encounter, diagnostic, and treatment data. In a rush to correct the problems with the legacy systems, ADS was developed to capture needed data for managed care. The DOD is relying on this system to provide patient encounter data to base cost adjustments between the DOD and Contractor, called bid price adjustments (BPAs), for the managed care support contract. However, ADS has experienced major design flaws and the output is still not validated at this time. The ultimate goal of ADS, once design flaws are corrected, will be to provide input to the target migration system - CEIS.

2.) CHAMPUS Detail Information System (CDIS) - supports on-line, near real-time accessing and retrieval of individual detailed CHAMPUS information.

3.) Composite Health Care System (CHCS) - a DOD-wide automated information system (AIS) which includes modules for tracking patient appointing, enrolling and disenrolling; laboratory, radiology, and pharmacy order entry; nursing; and clinical dietetics.

4.) Clinical Information System (CIS) - provides support for patient care management through critical and traditional plans of care as well as clinical case management. It also provides a clinical repository for reference and MTF-specific data, and automated data capture for physiological monitoring, waveforms, and automated medical instruments.

It is important to note interim migration systems were designed quickly to assist in development and collection of clinical micro level data for the government pricing of managed care support contracts. They are also used for the data collection period (DCP)

which is the one-year period before the start of health care delivery under the managed care contract. The DCP data is used to revise the initial bid price of the contract and future projections during the five option periods. Once the contract is underway, bid price adjustments will be accomplished every quarter by using actual claims and enrollment data to adjust the bid price. However, the DOD currently does not have the capability to collect and validate the needed data for bid price adjustments.

There are four target migration systems being developed which are designed to replace all other systems. The systems are:

1.) Corporate Executive Information System (CEIS)—a composite system which will support the DOD health care managers' need for executive information and decision support by providing consistent management information to decision makers at the MTF, Intermediate Headquarters, Services, and Health Affairs levels across the operational continuum.

2.) Composite Health Care System II (CHCS II)—a composite system which will integrate support to the clinical delivery processes within MHSS MTFs including all aspects of ancillary, order entry, and documentation in peacetime and time of war.

3.) Defense Medical Logistics Standard System II (DMLSS II)—a composite system which will provide integrated support to all logistics functions within the MHSS environment including all aspects of facility, equipment, and materiel management across the operational continuum.

4.) Health Standard Resources System (HSRS)—a composite system which will provide integrated support to all resources functions within the MHSS environment

including all aspects of financial and human resources management in peacetime and time of war.

These systems will have standardized data dictionary sets. The information, which now feeds the legacy systems, with individual data dictionary sets, will be input to the various target migration systems. The data when processed from various entry ports will be standardized, thus eliminating redundancy. There are stumbling blocks in the way of achieving the target migration systems. First, the DOD Services tend to be parochial once a system has been developed and put into use. New information systems are not easily accepted at the onset. Next, is a valuable resource the DOD doesn't have—time. A system such as CEIS is only in its developmental phase now, with testing one to two years out, and deployment three to five years away. The DOD is relying on this system to provide data needed for the survival of TRICARE. TRICARE has already been operational for four years in some regions. Those regions have been less than successful at reconciliation of bid price adjustments between the DOD and Contractor for services rendered.

Notes

[1] "Military Health Services System Automated Information Systems Plan, Version 2.2," August 1994, n.p.; on-line, Internet, 1 December 1997, available from http://hawww.ha.osd.mil:80/dmim/ais/ais_toc.html#1.1.

[2] Defense Medical Information Management (DMIM) Office, "MHSS Automated Information Systems (AIS): As of 5 July 1996," n.p.; on-line, Internet, 1 December 1997, available from http://www.ha.osd.mil/dmim/ais_list.html.

Chapter 4

Reimbursement Procedures for TRICARE

This chapter will address one of many problems facing the DOD in its transition to enrollment based capitated funding of military MTFs. The number one problem is operational issues concerning capitation-based resource allocation for MTFs. The Contractor who is awarded the managed care support contract (MCSC) can propose to capitate portions of care provided such as pharmacy and other ancillary services, however, the majority of services offered by the Contractor are paid based on a fee-for-service methodology. It is only the MTFs, which will operate under a capitated method of funding.

The problem of capitation-based resource allocation will be addressed in three categories. First and foremost one does not become an expert in managed care overnight. Second, as big as the DOD is, it cannot make a transition in health care delivery quickly and smoothly. Finally, one must recognize the differences in mission between military and civilian health care.

When the Department of Defense (Office of Assistant Secretary of Defense, Health Affairs) initiated managed care in 1993, there were no managed care experts in the military. Health Affairs performed several test projects and research based on the civilian sector's experience in managed care. Based on that knowledge, Health Affairs developed

a basic model for a managed care plan. Health Affairs then began to hire many consultants to assist in the formulation of a complete managed care support contract and data to support the transition to managed care. Even with the assistance of consultants, there continues to be problems with the basic Request for Proposal (RFP) in which the potential Contractors base their bids for the contract. Although the consultants mean well, and may be experts in managed care, they are not familiar with the military health care system, which includes CHAMPUS, and the flaws of our system.

The DOD failed to perform two important steps, actuarial studies and risk sharing analysis, before determining the capitated rate for MTFs. Without this important data, it is very difficult to establish a true capitated, fixed price method of resource allocation. In addition, there was no underwriting performed and a lack of proper cost accounting systems available among the three military services involved; Army, Navy and Air Force. The premise for determining the maximum cost of a managed care support contract is the historical total CHAMPUS costs for a region.[1] This has left the DOD with a method of determining the capitated rate, which is too simplistic and inaccurate at best. Establishment of a capitated rate must account for utilization and intensity of services provided to previous CHAMPUS users who did not use the direct military health care system (the MTFs) before the start of the contract. The current method to establish the capitated rate neglects to take three considerations into effect.

First is MTF costs. The costs of MTFs providing services need to be addressed. This may be greater or lesser than the CHAMPUS costs depending on the cost structure of the MTFs, i.e., minimal increases in marginal costs, or investment of revenues to support increased fixed and/or variable costs. Management of risk by the MTFs requires

defining the resources required to deliver care, which could be acquired from provider claims data, and defining the relevant characteristics of the patient pool, using population-based data. Barring a true actuarial analysis, a capitated rate can be calculated for the projected enrollment population. The capitation rate should be the projected utilization rate multiplied by MTF cost per service divided by 1,000 members times 12.

The second consideration is changes in plan design and subscribers. CHAMPUS users enrolling in the MTF Prime will no longer experience moral hazard in the sense there will be no copayments and deductibles (excluding retirees and those members referred to the civilian Prime network). Empirical studies show that moving to an enhanced benefit plan, with reduced moral hazard, will result in a greater usage of services, even with utilization management/demand management in place. The DOD is assuming a "managed care savings", though common sense suggests initially there will be an increase in services consumed and a corresponding increase in costs for the MTFs, although some may be just marginal costs.

The last consideration is the safety margin and profit margin. An historical look back at previous CHAMPUS costs does not underwrite the cost of care for those enrollees who did not incur CHAMPUS expenditures. This is obviously not a capitated rate, but rather just a transfer of revenue from one funding source to another. Capitation rates represent the cost on a per-capita basis of providing services to enrolled members. It is the average cost of providing services to members of the entire enrolled population for a given period of time.

If the DOD is really going to operate a business model similar to a civilian HMO, then the DOD should identify both a safety margin or catastrophic cap on expenses for

new enrollees, plus a profit margin for the MTFs. The DOD is asking MTFs to assume a risk with no incentives. The proposed financial calculations are too risky as it is based on enrollee unique prior costs. This method of financing leads the MTF Commanders to ask the question, "How and when will the new revenue flow to the MTF?" Specifically, if the managed care support contract start of health care delivery date occurs in CY97, when will the MTFs see the new revenue—will the DOD wait until the middle of the next calendar year which will be the third quarter of the fiscal year? The MTF Commanders are concerned the DOD will provide money late in the fiscal year (analogous to fall out money) which does not allow the MTFs to be proactive and use funds to match the MTFs strategic goals. The MTFs will have analyses of the potential type and intensity of services, which will be consumed. Providing the funds early will allow them to restructure to anticipate the increased demand.

Because of questions like mentioned above, the DOD has altered the financing mechanism of the MTFs. Since 1993, there have been three major changes. First, the DOD began with a military unique capitation method, which was actually a fixed budget. In 1995, the second method called revised financing was put into effect. It addressed charges, costs and capacity, but did not address the entire beneficiary population. Third, is the current method called enrollment based capitation (EBC), implemented in 1997.[2] EBC is heavily dependent on information systems and data, which the MTFs do not currently have. There are many unanswered questions concerning the financing of the MTFs and as a result it appears the DOD has put out for bid, a multi-billion dollar contract without first defining exactly how it will be paid for and how the money will flow to the MTFs. After reviewing the Health Affairs guidelines and method of payment

for managed care support contracts, it appears they are not based on a capitated rate per member, with shared risk between the DOD and the Contractors, but rather a fixed budget per Region/MTF, and the majority of the risk shouldered by the DOD and the MTF Commanders.

The next category, which presents a problem with the financing of managed care support contracts, is DOD bureaucracy. It cannot make a major transition quickly and smoothly. One reason the DOD is so slow is the fact that within the DOD there are three separate services with their own missions and methods of managing resources. This has a direct affect on the MTFs and how each one is funded. Congress allocates total funds for the DOD. Health Affairs receives the portion of DOD funds to pay for the Military Health Services System and in turn splits the funds among the three Services based on size and mission. The Services' Surgeons General then distribute funds to the intermediate service levels; the Major Commands for Air Force, Regional Medical Commands for Army, and the Bureau of Medicine for Navy. Each Service along the chain of command develops rules on how the funds will be allocated, controlled, and spent. In addition to the levels already in existence, Health Affairs developed yet another level, called the Lead Agent office, which is responsible for management of the managed care support contract for a region. One region can have MTFs from each Service, and various Major Commands, Regional Medical Commands and the Bureau of Medicine. The DOD has not attempted to streamline management of MTFs, which leaves the MTFs with a tremendous problem of who to coordinate with and many levels to answer to. For example, the intermediate service levels have control of resources and manpower for the MTFs. However, the Lead Agents are responsible for making the managed care system

work in the DOD. What is ironic about this is the DOD has invested billions of dollars in managed care and many political lives are at stake. Yet, they laid the massive responsibility of ensuring the managed care system works in the laps of Lead Agent offices, which have no control of resources and manpower at the MTF level. In addition, Major Commands, Regional Medical Commands and the Bureau of Medicine feel threatened by the Lead Agent staffs and tend to work against them. This situation obviously puts the MTFs in an awkward position of where to place their loyalties and clearly establishes the fact that at various levels of the Military Health Services System there has not been complete buy-in to the transition of managed care in the military. It leaves some to wonder if the DOD can successfully make the transition or if the DOD is really doing business the same old way yet calling it something new. A very important point to this topic is that the MTFs often receive conflicting guidance and directives as to how the MTFs will be financed and what can or cannot be done with certain types of funds. Also, it is important to point out the missions of the intermediate service levels and Lead Agents are diametrically opposed to each other. For example, intermediate service levels fund MTFs based on user population within a catchment area. This does not take into account factors of the managed care support contract such as stringent access standards. Lead Agent offices have recommended to MTFs that they cut back on the number of people they now treat when establishing the primary care manager (PCM) ratios. Under the contract there are strict requirements to meet. If MTFs do not meet the same standards the Contractor is required to meet, it will cost the DOD millions of dollars through the bid price adjustment process. However, intermediate service levels disagree with a 1200:1 to 1500:1 PCM ratio, and threaten to cut resources and manpower from the

MTFs. This leads back to the questions mentioned before by the MTF Commanders about when will the new revenue begin under managed care and will the MTFs get caught in the transition with no source of funding? Also, who will be controlling the funding source?

Finally, the third category, which creates a problem for capitation-based resource allocation in the military system, is differences between military and civilian health care. The true definition of capitation-based rates cannot be the same as the civilian sector because the funds used for military medicine have to be split between delivery of care during peacetime and war. According to Tittle 10, the primary mission of military health care is preparedness for the war time mission. Peacetime health care is simply provided on a space available basis, and if the military direct care system cannot handle the capacity of those who need to be seen in the MTFs, all but the Active Duty, must use CHAMPUS.

As stated earlier, the cost of managed care support contracts is based on the historical CHAMPUS costs for a particular region. This formula does not taken into account the cost to the MTFs for medical readiness exercises and deployments. The typical civilian full time equivalent (FTE) PCM to enrollee ratio is 2000:1. After deducting the time from military providers for medical readiness requirements and other military related functions the military FTE PCM to enrollee ratio is 1200 to 1500:1. Another difference is the way in which providers schedule patients. Military providers do not have any incentive to increase patient loads because they are salaried employees of the DOD. If they see one or one hundred patients a day the monetary outcome is the same. They receive no bonuses or penalties for either reducing costs or spending too much on patient

care. Military medicine has never been and never will be a "for profit" or "bottom line" system. MTFs are used to operating based on a fixed budget, divided by four quarters and hoping for extra fall out money at the end of each fiscal year to purchase high dollar equipment. There are too many unanswered questions for the MTF Commanders to feel comfortable with the managed care method of financing, especially since so much risk is placed at the front door of the MTFs. The MTF Commanders have been told they will be held responsible for MTF expenditures under managed care. If the MTFs save money, it has not been defined if the MTFs retain the cost savings at the MTF level, or if the Major Commands, Regional Medical Commands, and the Bureau of Medicine retain the funds. If that is the case, the MTF Commanders have no incentive to save money and increase enrollment to the MTFs. The only incentive is a negative one. MTF Commanders feel if they turn any enrollees over to the Contractor, they will in effect be putting themselves out of business.

Notes

[1] Department of Defense, *TRICARE Policy Guidelines* (Washington, D.C.: Office of Assistant Secretary of Defense [Health Affairs]), May 1995.

[2] Department of Defense, *Enrollment Based Capitation Implementation Guidelines* (Washington, D.C.: Office of Assistant Secretary of Defense [Health Affairs]), October 1997.

Chapter 5

Conclusions

The desire to provide health care to all MHSS beneficiaries is evident in the DOD. However, that is no longer possible just using MTFs and CHAMPUS. The TRICARE program took a wrong turn at the very beginning when it was initially promoted as being able to provide an HMO model of health care to everyone, no matter where they lived. Although that may have been the original objective or desire, it is simply cost prohibitive. The DOD should not use smoke and mirrors to sell TRICARE. TRICARE has been "marketed" as a new and improved program with enhanced access and benefits package. In reality, it is a cost cutting measure and a means to reduce services provided through MTFs, by shifting care to a civilian Contractor network. Health Affairs has wasted too much money on a TRICARE marketing office if the staff of TMO is only responsible for providing promotion and education activities. At all levels of the DOD there are existing Public Relations officers who are trained and experienced at informing the public about new government initiatives. The implementation of the TRICARE program should be no different.

In addition to taking wrong turns during the marketing process, the DOD has also taken two parallel roads full of obstacles when it comes to the use of information systems. The DOD began the planning and implementation of TRICARE with obsolete

systems, which were not designed to provide or validate the needed data. In addition, there are 128 information systems in the MHSS, which do not "communicate" with each other and provide conflicting data. Hopefully these two roads will come together in the near future because the success of TRICARE and military medicine depends on it. Obstacles such as the inability to obtain substantial, validated data to support the TRICARE effort; and the development, deployment and use of ADS, CEIS and CHCS II long after the implementation of TRICARE are problems which must be solved soon, especially with the implementation of the enrollment based capitation method of financing. Not only are operational issues involved, there are also political issues to address. The DOD cannot defend its actions to Congress, Lobbyist, and critics without accurate data to benchmark the military health care system against the civilian sector. Some politicians and critics are waiting for TRICARE to fail, wanting other programs used and (or) budget cuts. If the DOD is dependent on ADS, CEIS and CHCS II to provide desperately needed data to cost out and measure multi-billion dollar managed care support contracts then it could already be too late. If the DOD cannot make the two roads merge soon, then billions of taxpayers' money will be wasted.

Additional bumps along the road of TRICARE implementation still to be smoothed out are the major issues in the area of financing. It is clear the DOD must reduce the cost of health care and provide quality service and access to the beneficiaries of the Military Health Services System. During this time of base closures and manpower reductions, there is anxiety throughout the various levels of the DOD that this is a last ditch effort to save military health care as we know it. No one in military medicine wants a majority Contractor operated health care system with just the war time medicine and Active Duty

members belonging to the military. There are several studies being conducted and with any government study goes political pull to sway the study's outcome. These studies are looking at doing away with managed care as it currently is and going with another plan in existence, the Federal Employee Health Benefit Plan (FEHBP), which has been proven to cost the government more than the current managed care contracts. There are other studies looking at closing all but just a few military medical treatment facilities and civilianizing care to all but the Active Duty population.

With these and many other issues looming over the heads of those charged with developing and delivering quality care to eligible beneficiaries in the MHSS, it is easy to understand the importance of developing detailed plans and procedures before the implementation of the TRICARE program. The leadership of the Military Health Services System knows managed care is the way to go, but once again it appears the DOD put the cart before the horse. In an effort to save the military medical system, the DOD implemented a major 15 billion dollar managed care program without a thorough and concise plan as to how important processes such as marketing, information systems and reimbursement procedures would be implemented.

It is hard to imagine a corporation such as IBM or Ford Motor Company implementing a new 15 billion dollar program without first having plans for marketing the new product, having information systems developed and in place before the planning and implementation phases, and contracting with manufacturers for out-sourcing without knowing how the new program would be financed. Based on that scenario one would come to the conclusion that the company would fail. Thus, one could assume the same

fate would fall upon the Department of Defense as it attempts to implement TRICARE and if this attempt fails so may the entire military medical system.

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